No. 18-10545

In the United States Court of Appeals for the Fifth Circuit

STATE OF TEXAS; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF INDIANA; STATE OF WISCONSIN; STATE OF NEBRASKA,

Plaintiffs-Appellees / Cross-Appellants,

v.

CHARLES P. RETTIG, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INTERNAL REVENUE; UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES INTERNAL REVENUE SERVICE, ALEX M. AZAR II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants-Appellants / Cross-Appellees.

On Appeal from the United States District Court
for the Northern District of Texas, Wichita Falls Division

PLAINTIFFS-APPELLEES / CROSS-APPELLANTS PRINCIPAL AND RESPONSE BRIEF

COUNSEL LISTED ON THE INSIDE COVER

KEN PAXTON
Attorney General of Texas

JEFFREY C. MATEER
First Assistant Attorney General

DAVID J. HACKER
Special Counsel to the First Assistant Attorney General

KYLE D. HAWKINS
Solicitor General

LANORA C. PETTIT
Assistant Solicitor General
lanora.pettit@oag.texas.gov

Office of the Texas Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Tel.: (512) 936-1700
Fax: (512) 474-2697

Counsel for Plaintiffs-Appellees / Cross-Appellants States of Texas, Kansas, Louisiana, Indiana, and Nebraska

Certificate of Interested Persons

No. 18-5045

State of Texas; State of Kansas; State of Louisiana; State of Indiana; State of Wisconsin; State of Nebraska,

Plaintiffs-Appellees / Cross-Appellants,

v.

Charles P. Rettig, in his Official Capacity as Commissioner of Internal Revenue; United States of America; United States Department of Health and Human Services; United States Internal Revenue Service; Alex M. Azar II, Secretary, U.S. Department of Health and Human Services,

Defendants-Appellants / Cross-Appellees.

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees / Cross-Appellants:
State of Texas
State of Kansas
State of Louisiana
State of Indiana
State of Nebraska

Counsel for Plaintiffs-Appellees / Cross-Appellants:
Ken Paxton
Jeffrey C. Mateer
David J. Hacker
Kyle D. Hawkins
Lanora C. Pettit (lead counsel)
Austin Nimocks
Andrew D. Leonie

Michael Christopher Toth
Randal Wilson Miller
Thomas A. Albright
Office of the Texas Attorney General
P.O. Box 12548
Austin, TX 78711

Plaintiff-Appellee:
State of Wisconsin

Counsel for Plaintiff-Appellee:
Corey F. Finkelmeyer (lead counsel)
Steven Carl Kilpatrick
Wisconsin Department of Justice
P.O. Box 7857
Madison, WI 53707

Defendants-Appellants / Cross-Appellees:
Charles P. Rettig, in his Official Capacity as Commissioner of Internal Revenue
United States of America
U.S. Department of Health and Human Services
U.S. Internal Revenue Service
Alex M. Azar II, in his Official Capacity as Secretary, U.S. Department of Health and Human Services

Counsel for Defendants-Appellants / Cross-Appellees:
Jody H. Hunt
Deepthy Kishore
Rohit Dwarka Nath
Sheila Lieber
Julie Straus Harris
Michelle Bennett
Mark B. Stern
Alisa B. Klein
Joshua Revesz (lead counsel)
U.S. Department of Justice
950 Pennsylvania Ave NW
Washington, D.C. 20530

Erin Nealy Cox
United States Attorney for the Northern District of Texas
1100 Commerce Street
Dallas, TX 75242

Robert P. Charrow
Kelly M. Cleary
Brian R. Stimson
Janice L. Hoffman
Susan Maxson Lyons
U.S. Department of Health & Human Services
200 Independence Ave SW
Washington, D.C. 20201

/s/ Lanora C. Pettit
LANORA C. PETTIT
Counsel of Record for Plaintiffs-Appellees / Cross-Appellants States of Texas, Kansas, Louisiana, Indiana, and Nebraska

Statement Regarding Oral Argument

Plaintiffs-Appellees / Cross-Appellants, the States of Texas, Kansas, Louisiana, Indiana, and Nebraska (collectively, "Appellant-States"), respectfully request oral argument.[1] In 2010, Congress imposed an unprecedented tax on health-insurance providers whom it expected to receive a windfall from the Affordable Care Act's mandate that nearly all Americans buy insurance. States, who would not participate in that windfall, were exempted from paying the tax. It is nonetheless undisputed that Defendants-Appellants (collectively, the "United States") are in possession of nearly $500 million of the Plaintiff-States' money as a result of this tax.

The regulatory mechanism by which that money traveled is complex. Through the intermediation of private parties and a rule promulgated under a statute passed in 1981, two agencies of the Executive Branch threatened to cut off States' Medicaid funding if they did not pay this tax. The district court correctly ordered monies paid to date to be returned on the ground that the Constitution does not allow private parties to pass rules that impose taxes on sovereign States. It should also have held, however, that the tax could not be imposed on the States at all, and particularly not as a condition on receipt of Medicaid funding. Appellant-States respectfully submit that oral argument will aid the Court's adjudication of this case, which involves numerous difficult and interlocking issues of constitutional, statutory, and administrative law.

[1] Wisconsin participates in this appeal only as Plaintiff-Appellee. To avoid confusion, this brief will use the term "Plaintiff-States" when it discusses all States who appeared in the district court as plaintiffs, including Wisconsin.

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INTRODUCTION

The Patient Protection and Affordable Care Act (the "Act" or "ACA"), Public Law 111-148, 124 Stat. 120, § 9010 (Mar. 23, 2010), was a "monumental piece of . . . legislation that regulates a huge swath of this nation's economy" with a goal of universal healthcare. *Texas v. United States*, 945 F.3d 355, 368 (5th Cir. 2019). A "focal point of our nation's political debate" since its inception, *id.*, the Act resulted from a series of parliamentary maneuvers conducted well outside the public view. Conscious of the bill's detrimental impact on the fisc, its proponents designed elaborate mechanisms to spread the burden across all participants in the healthcare market, including the health-insurance-provider fee ("HIPF") at issue in this case. ACA § 9010. The theory behind this fee was that the Act would cause so many people to buy health insurance that insurance providers should help offset the cost of the program by paying additional taxes.[2] States were expressly exempted from this assessment, even though they usually operate their Medicaid programs by contracting with companies in the private health-insurance market. *Id.* § 9010(c)(2)(B).

Unsatisfied with the compromise struck by Congress, the United States has imposed the HIPF on States through a highly complicated regulatory device. In 1981, Congress required that if States choose to outsource their risks in providing Medicaid benefits to insurance companies, they must pay those companies rates that are

[2] The HIPF is designated a "fee" but treated, for certain purposes, as a tax. ACA § 9010. As none of the arguments in this brief turn on the distinction, Appellant-States follow the district court in using the term "tax." This is to avoid confusion, not a concession that the HIPF should be treated for any particular purpose as a tax.

actuarially sound. In 2002, the Department of Health and Human Services promulgated a regulation (the "Certification Rule") that defined actuarial soundness to require each contract to be certified by a private actuary based on standards set by a private organization, the Actuarial Standards Board (the "Board"). In 2014, the Internal Revenue Service began charging all insurance companies, including those managing state Medicaid programs, the HIPF. In 2015, the Board issued a set of standards that require States to pay the HIPF for their insurers and that subject any actuary who certifies a contract that does not comply to professional discipline. Because the States cannot receive Medicaid reimbursement without that actuarial certification, the United States has forced them to choose between paying the HIPF or explaining to their citizens why they lost billions of dollars in Medicaid funding.

Plaintiff-States brought this suit to challenge both the HIPF and the Certification Rule on numerous statutory and constitutional grounds. The district court upheld the HIPF itself as a constitutional tax but struck down the Certification Rule because using a private entity to impose that tax on States violated the nondelegation doctrine. In a move that directly contradicts arguments that it successfully made to the district court (*e.g.*, ROA.3323-24), the United States now asserts that the Certification Rule is not a delegation problem because Congress imposed it on States as a condition on Medicaid spending.

The federal government does not get to have it both ways. Either Congress imposed the HIPF, enacting a condition on Medicaid spending that violates the limits imposed by *National Federation of Independent Business v. Sebelius* (*"NFIB"*), 567 U.S. 519 (2012), and the Tenth Amendment. Or the Board imposed the HIPF,

promulgating a regulation that violates the nondelegation doctrine and the Administrative Procedures Act, 5 U.S.C. § 500, et seq. Either way, States have been forced to pay nearly $500 million under a tax from which they were exempted. They (and their taxpayers) are entitled to get that money back.

Statement of Jurisdiction

The district court had jurisdiction pursuant to 28 U.S.C. § 1331 and entered final judgment on July 30, 2019. ROA.4675-77. Timely notices of appeal and cross-appeal were filed on September 26 and 27, 2019. ROA.4700, 4703. This Court has jurisdiction pursuant to 28 U.S.C. § 1291.

Issues Presented

Appeal

1. Whether Congress's decision to exempt States from paying the HIPF should be given practical effect.
2. Whether federal jurisdiction exists because:
    a. States have standing to challenge a tax they have paid; and
    b. The APA waives immunity over the Complaint's claims for monetary relief.
3. Whether allowing private parties to exercise binding governmental authority violates the nondelegation doctrine.

Cross-Appeal

4. Whether imposition of the HIPF on Appellant-States is substantively or procedurally improper under the APA.

5. Whether the HIPF, as applied to the States, is unconstitutional under:
   a. The Spending Clause; or
   b. Principles of intergovernmental tax immunity.
6. Whether, in the alternative to equitable disgorgement, Appellant-States are entitled to seek a tax refund.

STATEMENT OF THE CASE

A. Medicaid and Its Delivery Mechanisms

Since 1965, Medicaid has been the preeminent example of the growth of "cooperative federalism," under which programs are "financed largely by the federal government," but "administered by the States." *King v. Smith*, 392 U.S. 309, 316 (1968). Congress has made federal funds available to States to provide medical assistance to certain categories of needy individuals. So long as States meet certain criteria, they are provided with considerable leeway to pursue their own healthcare policy objectives with that money. 42 U.S.C. §§ 1396, et seq. Because meeting the healthcare needs of their underprivileged citizens is a significant priority for States, Medicaid represents a substantial portion of their overall budgets.[3] For example, in 2015, Texas spent 28.6% of its budget on Medicaid, of which 56.2% was received from the federal government. TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID AND CHIP IN PERSPECTIVE 1–5 (11th ed. 2017),

[3] *See* U.S. Dep't of Health and Human Servs., *Profiles and Data Collections*, https://www.medicaid.gov/medicaid/managed-care/state-profiles/index.html.

https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf.

States have two basic choices on how to provide care for these individuals: a fee-for-service model and a managed-care model. In the program's formative years, Medicaid was provided almost exclusively on a fee-for-service basis. ROA.1860. A doctor who treated a Medicaid beneficiary submitted a reimbursement request to the State Medicaid agency, and the State paid the bill after confirming the individual's eligibility and need for the service. The State then sought reimbursement from the federal government for a percentage of the cost, typically on a quarterly basis. MACPAC, *Fact Sheet: The Medicaid Fee-for-Service Provider Payment Process*, July 2018, https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-fee-for-service-provider-payment-process.pdf; *cf. Bowen v. Massachusetts*, 487 U.S. 879, 884-85 (1988). This model functions much like the uninsured healthcare market because the State pays nothing for patients who are in good health and faces enormous costs for patients suffering from serious illness or injury who require significant care. It has been criticized for, among other things, leading to "low levels of medical screenings, vaccinations," and other preventative care, ROA.1860, and higher rates of more expensive, emergency care, ROA.1611.

Due to inefficiencies in the fee-for-service model, States began switching to the managed-care model in 1982. ROA.1860. Under this new model, States contract with private insurance companies, known as managed-care organizations ("MCOs"), to coordinate care provided to Medicaid beneficiaries. ROA.3083-84.

Like employer-funded health insurance, beneficiaries may choose between preselected options. 42 C.F.R. § 438.52. The State then pays the MCO a monthly premium, known as a "capitation," for each beneficiary, regardless of whether the individual requires care. ROA.3083-84. Under this model, the MCO rather than the State bears the risk that any individual will require costly forms of care. MCOs are thus incentivized to encourage patients to have a primary-care physician and seek treatment early, rather than wait until they are very sick. ROA.1611-1615.

Though a matter of dispute in the district court, the United States now acknowledges (at 1) that MCOs have become the "typical[]" method of providing Medicaid services. Indeed, as the federal government's own authority suggests, promoting this transition has been a goal of policymakers aimed at cracking down on payment abuse. Aaron Mendelson et al., *New Rules for Medicaid Managed Care — Do They Undermine Payment Reform?*, 4 HEALTHCARE 274, 274 (2016); ROA.1611. And that goal has largely been achieved. As of 2017, approximately 88% of Texas Medicaid patients were served by MCOs. ROA.284. As of late 2016, 92.5% of Louisiana's Medicaid beneficiaries received services through MCOs. ROA.1889.

B. Adoption and Early Application of the Certification Rule

In 1981, as the managed-care model emerged but before industry norms regarding payment rates developed, Congress imposed several limitations on States' ability to contract with MCOs. Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357, § 2178. One such limitation was that payments under an MCO contract must be "made on an actuarially sound basis." *Id.* (codified at 42 U.S.C. § 1396b(m)(2)(A)(iii)). Congress has never defined what "actuarially sound" means

in this context, and for many years, that term remained undefined even by the actuarial profession. *Cf.* ROA.473. The concept of actuarial soundness, however, is generally designed to ensure that MCOs cover their costs without making excessive returns, thereby protecting both MCOs and taxpayers.

HHS, which oversees the Medicaid program through the Centers for Medicare and Medicaid Services, has struggled to define actuarial soundness with any greater specificity. Until 2002, HHS regulations defined actuarial soundness to mean that payments under a managed-care model could not "exceed the cost . . . of providing those same services on a fee-for-service basis." 42 C.F.R. § 447.361 (repealed 2002). By the late 1990s, however, this system had become unworkable. A new model was needed, not as the United States suggests (at 8) because States wanted increased flexibility, but because the managed-care model was so prevalent that existing fee-for-service data was insufficient to allow the comparisons required under the old rule. ROA.471.

HHS responded by adopting a new rule focused on a certification process for MCO contracts, rather than a specific benchmark as had existed previously. Initially, the process would require States to certify that their rates were actuarially sound. 66 Fed. Reg. 6228-01 (Jan. 19, 2001). Insurance companies, like the amici, objected that this proposed process did not protect their margins. *E.g.*, ROA.665, 672, 681. Other parties objected that HHS should create actual "prescriptive standards for actuarial soundness." ROA.1411. HHS struggled with how to define "actuarial soundness" for so long that it had to extend the effective date of the regulations, drawing complaints (including from members of Congress) that it had failed to comply with the

APA. ROA.784-89. Needing to define an indeterminate term, HHS punted and decided to outsource its work to the Board, a private, standard-setting organization. ROA.1411. Thus, the Certification Rule was born.

Under the Certification Rule, States must develop rates "in accordance with generally accepted actuarial principles and practices," and the rates must be certified by an "actuar[y] who meet[s] the qualifications established by the American Academy of Actuaries and follow the practice standards established" by the Board. 42 C.F.R. § 438.6(c).[4] Though it has informal ways of setting nonbinding guidance, the Board promulgates its binding rules through Actuarial Standards of Practice ("ASOPs"). An actuary may be disciplined for "[f]ailure to comply with an applicable ASOP." ROA.1810. The United States now asserts (at 10) that the Board's standards "align[] with HHS Guidance" but does not dispute that the Certification Rule effectively allows the Board to set standards by which Medicaid MCO contracts—and therefore States' ability to receive federal reimbursement—are judged as a matter of federal law.

When the ACA was being debated, there was no ASOP "that applie[d] to actuarial work performed to comply with [HHS]'s regulation." ROA.3087 (2010 GAO Report 10-810). At most, there was a nonbinding 2005 "practice note" that "proposed [a] definition for 'actuarial soundness' [because] there was no other working definition of [that] term." ROA.3087. Under that practice note, actuaries were

[4] Like the United States, Appellant-States use the regulations in effect at the time the operative complaint was filed.

permitted but not required to consider fourteen separate factors in assessing expected MCO revenues and expenses under contracts with State Medicaid agencies, including any "state-mandated assessments and taxes." ROA.1864-65. Actuaries were advised, however, that their analysis must comport with state and federal law. *E.g.*, ROA.1807. At the time, federal taxes were minor and not separately considered. ROA.2598, 2754.

C. The ACA and HIPF

In 2010, the ACA created the first federal tax on health-insurance premiums. The new tax was highly unusual in that it was not applied to an entity's revenues or net income. Instead, Congress set an annual assessment on the entire health-insurance industry. ACA § 9010(b)(1); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, § 1406(a)(3).[5] "Each covered entity engaged in the business of providing health insurance" then pays the IRS a "fee in an amount determined" by multiplying that assessment by the entity's market share of "premiums written" in the health-insurance market. ACA § 9010(b). This fee is treated as a non-deductible excise tax for certain tax purposes. *Id.* § 9010(f).

Covered entities include "any entity which provides health insurance" *except* "any government entity." *Id.* § 9010(c)(2)(B); 26 C.F.R. § 57.2(b)(2)(ii)(B). It is

[5] The United States's statement (at 5) that the ACA was "subsequently amended" by the Reconciliation Act of 2010 is misleading. These statutes are functionally the same bill, which was passed in two pieces because the ACA's proponents lost their filibuster-proof majority in the Senate. *See* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 L. LIBR. J. 131, 163 (2013).

undisputed that States are "government entities" for the purpose of this definition. Therefore, under the plain language of Section 9010, Congress exempted States from paying the HIPF.

D. ASOP 49

In March 2015, in response to criticism from the Government Accountability Office, the Board finally published a binding definition of "actuarial soundness" applicable specifically to Medicaid MCOs—ASOP 49. ROA.1649-81. ASOP 49 states that an MCO's capitation rate is "actuarially sound" only if "projected capitation rates . . . provide for all reasonable, appropriate, and attainable costs," including any "government-mandated assessments, fees, and taxes," ROA.1655, that are not tax deductible, 26 C.F.R. § 57.8. Unlike previous guidance requiring actuaries to account for federal law, ASOP 49 makes no allowance for the fact that Congress exempted States from paying the HIPF. Instead, States *must* pay the HIPF to comply with the ASOP, the Certification Rule, and thus the 1981 actuarial-soundness requirement. *E.g.*, ROA.1697, 3233.

E. Procedural History

In October 2015, Plaintiff-States brought this suit challenging the imposition of the HIPF. In the operative Amended Complaint, they sought declaratory relief that Section 9010 as it has been applied to the States exceeds Congress's spending and taxing powers. ROA.165-66, 168-72. They also challenged HHS's role in imposing the HIPF via the Certification Rule as unlawful under the APA, ROA.166-69, and the nondelegation doctrine derived from the Constitution's separation of powers,

ROA.159-63, 168. And they sought return of funds unlawfully collected by the IRS between 2014 and 2016. ROA.170-75.

In March 2018, the district court held that HHS violated the nondelegation doctrine by allowing a private entity to (1) formulate the standards that determine whether a State may receive Medicaid funding and (2) certify compliance with those standards. ROA.4000-10. The district court concluded, however, that the Certification Rule as adopted in 2002 was lawful under the APA. ROA.4014-15. The court rejected the States' tax-refund claim because it concluded that the States were not the relevant taxpayer. ROA.342-44. Moreover, the district court said, Congress did not exceed its taxing authority because it was the Board's "imposition of the HIPF on Plaintiffs, not the HIPF itself," that caused the alleged injury. ROA.4024. The district court rejected Appellant-States' Spending-Clause claims because the HIPF is a tax. ROA.4018. The district court concluded that because the ACA "prohibits [the United States] from collecting the HIPF from the states in the first place," equity requires the IRS to disgorge the nearly $500 million that Plaintiff-States have been required to pay to date. ROA.4411.

Summary of the Argument

I. Most of the United States's appeal is built on a single pillar, never previously raised in this litigation: that the States' exemption from paying the HIPF is limited to when they provide Medicaid services through a fee-for-service model. This newly discovered argument should be rejected as inconsistent with the language of Section 9010, which assesses a tax on entities that provide health insurance based on their market share. States operating a fee-for-service model are not "entit[ies] engaged in

the business of providing insurance," and they do not pay premiums. ACA § 9010. Thus, to have any effect, the exemption must apply when States contract with MCOs. Because the Court must give every provision of the ACA meaning, any argument that is built on this premise collapses under its own weight.

II. Similarly without foundation are the United States's jurisdictional challenges. The United States has wisely dropped many of its previous arguments about why jurisdiction does not exist in this case including, among other things, that HIPF did not injure the States. But those arguments the United States continues to press regarding Appellant-States' standing and ability to seek equitable disgorgement are also without merit.

A. As an initial matter, Appellant-States have not somehow conceded that their claims against HHS regarding the Certification Rule are not redressable because the IRS has continued to impose the HIPF on Medicaid MCOs. A claim does not fail for lack of redressability because a favorable ruling would cure some, but not all of the plaintiff's harm. *Larson v. Valente*, 456 U.S. 228, 242-43 (1982). Here, the district court ordered that HHS may not deny States Medicaid funding based on the Board's requirement that MCO contracts account for the HIPF. That order has not yet been implemented. In the interim, the IRS has continued to assess the HIPF to Medicaid MCOs using a separate regulation. And some of those Medicaid MCOs have continued to try to foist it off on States, but that is a distinct harm that may be addressed in a different lawsuit or through different claims.

B. The United States is also wrong to assert that Appellant-States' claims fall outside the APA's waiver of sovereign immunity because (1) they are time barred,

and (2) certain claims seek monetary relief. *First*, the claims are timely. A facial challenge to the procedures by which a rule was adopted must be made within six years of its placement in the federal register. *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985). But a new limitations period is triggered by a change to or application of that rule. *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997). Here, ASOP 49 was the first binding, substantive criterion that the Board ever promulgated specific to Medicaid MCO contracts. It was promulgated by the Board, adopted by HHS, and applied to Appellant-States less than six years before the States sued.

Second, Congress waived sovereign immunity for all claims challenging an agency action "seeking relief other than money damages." 5 U.S.C. § 702. Because Appellant-States seek return of particular monies to which they are entitled under a federal grant-in-aid program, rather than money damages, this waiver extends to their claims. *Bowen*, 487 U.S. at 893.

III. The district court properly held that the Certification Rule violates the nondelegation doctrine. Article I of the Constitution vests all power to make law in Congress. Congress may allow the Executive discretion to determine how law should be applied to particular facts. But general, substantive policies governing our nation *must* be passed by the legislature and signed by the President. *E.g.*, *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935); *cf. Dep't of Transp. v. Ass'n of Am. R.Rs.* ("*Amtrak*"), 575 U.S. 43, 55-56 (2015) (reaffirming principle and remanding for further consideration). Here, the United States has done something worse. Rather than passing the buck to a coequal branch of government, it has

allowed the Board, a private entity, to determine when States receive federal funds and to impose a tax in the process. Regardless of whether that entity is disinterested, this is delegation in its "most obnoxious form," and cannot be squared with the separation of powers. *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936).

IV. The Certification Rule's incorporation of ASOP 49 also cannot be squared with the substantive and procedural limits of the APA. Whatever discretion an agency may exercise consistent with the nondelegation doctrine, that discretion does not extend to changing the meaning of a statute. The Certification Rule purports to do precisely that by depriving the States' exemption from the HIPF of any meaning. It is thus substantively unlawful under the APA. Moreover, because ASOP 49 changed the substantive standards by which States' obligations are evaluated by removing discretion that actuaries previously had in assessing the HIPF to States, it cannot bind States because it has never gone through notice-and-comment rulemaking.

V.A. The district court further erred by rejecting Appellant-States' challenges to the HIPF itself. As the United States now affirmatively argues (at 18-19, 33), the HIPF must be considered a condition on spending—not simply a tax. That condition requires States to subsidize the care of individuals who are not eligible for Medicaid. Under *NFIB*, such a condition may not be imposed on States because (1) States lacked adequate notice of the condition when they agreed to join Medicaid in 1965, and (2) the amount of the funding at stake is coercive. 567 U.S. at 581-84.

B. The HIPF is independently unconstitutional because it violates Appellant-States' intergovernmental tax immunity. Though the federal government may pass

taxes on entities with whom a State does business, it may not tax a State if (1) the tax discriminates against States, or (2) the tax is not a traditional source of congressional revenue and interferes with State sovereignty. *Massachusetts v. United States*, 435 U.S. 444, 457-58 (1978) (discussing test adopted in *New York v. United States*, 326 U.S. 572, 586-87 (1946)). The HIPF, which is not a traditional source of revenue, does both: It discriminates against States because only States are required to pay 100% of the tax or lose Medicaid funds. Moreover, it impacts the sovereign functions of setting healthcare and budgetary policy.

VI. Because the HIPF was unlawfully collected from States, the district court was correct to order equitable disgorgement. If the Court disagrees, however, it should remand Appellant-States' claim for a tax refund for further consideration. The district court originally dismissed this claim based on an unduly restrictive interpretation of the term "taxpayer" in the Internal Revenue Code. It subsequently refused to reconsider that ruling because its disgorgement order afforded Appellant-States full relief. If the Court decides to reverse that equitable order, Appellant-States should be allowed to prove their statutory claim.

STANDARD OF REVIEW

This Court reviews a district court's grant of summary judgment *de novo*. *Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299, 304 (5th Cir. 2010). Where, as here, there are cross-motions for summary judgment, the Court "review[s] each party's motion independently, viewing the evidence . . . in the light most favorable to the non-moving party." *Id.* at 304 (quoting *Ford Motor Co. v. Tex. Dep't of Transp.*, 264 F.3d 493, 498 (5th Cir. 2001)). The equitable disgorgement order is reviewed

for abuse of discretion. *SEC v. AMX Int'l, Inc.*, 7 F.3d 71, 73-74 (5th Cir. 1993) (per curiam).

ARGUMENT

I. The ACA Exempted States Providing Medicaid Through a Managed-Care Model from Paying the HIPF.

The United States concedes (at 1) that States "typically" provide Medicaid through a managed-care model. Nevertheless, central to its appeal is a newly raised argument that the States' exemption from paying the HIPF applies only when States provide services directly through a fee-for-service model. U.S. Br. 20-22; *see also* Blue Cross Br. 6. This position cannot be squared with the language, structure, or purpose of Section 9010 of the ACA.[6]

First, the argument ignores that, in a fee-for-service model, States would not be subject to the HIPF because they are not "in the business of providing health insurance." ACA § 9010(a)(1). States are not businesses. And the ordinary meaning of the term "insurance" denotes a "contract by which one party undertakes to indemnify another party" against "a risk of loss." BLACK'S LAW DICTIONARY 920 (10th ed. 2014). Indeed, the Supreme Court has long held that the "*indispensable* characteristic of insurance" is "underwriting or spreading of risk." *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212 (1979) (emphasis added) (citing *SEC v.*

[6] The United States is incorrect when it asserts (at 12) that the operative complaint does not claim that the ACA exempts States using a managed-care model from paying the HIPF. ROA.169. Plaintiff-States also consistently argued this position in their briefing and oral argument. *E.g.*, ROA.1583, 4149, 4288.

Variable Annuity Life Ins. Co., 359 U.S. 65, 79 (1959)); *Helvering v. Le Gierse*, 312 U.S. 531, 540 (1941).[7] In a fee-for-service model of Medicaid, there is no contract and no transfer of risk, simply payment. As when providing housing vouchers or public education, States are sovereigns paying for a public service. It is unnecessary to examine the legislative history of the ACA because the text is unambiguous. *E.g. Mohamad v. Palestinian Auth.*, 566 U.S.449, 458-59 (2012). But that history further confirms that because fee-for-service arrangements do not function as insurance, the HIPF does not apply. *See* JOINT COMM. ON TAXATION, TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT," JCX-27-10, 89 (Mar. 21, 2010).

Second, the United States ignores that the HIPF is calculated based on a covered entity's share of the health-insurance market based on "premiums written." ACA § 9010(b)(1). States paying on a fee-for-service basis are not paying "premiums" and thus would require no exception from the HIPF. Premiums are the "amount paid at designated intervals for insurance"—regardless of whether a beneficiary receives services. BLACK'S LAW DICTIONARY 1371 (10th ed. 2014). An exception from the

[7] Even where the law allows "self-insurance," the insurer still must spread risk across a pool of people, not just pay out of pocket. *Thompson v. Goetzmann*, 337 F.3d 489, 498-99 (5th Cir. 2003) (per curiam).

HIPF for States has effect only when States pay premiums to MCOs.[8] The United States's argument is thus contrary to the bedrock rule of statutory interpretation that a law must be read, where possible, to give every section meaning. ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 167 (2012). This Court should reject any reading of the States' exemption that "renders it pointless." *Id.* at 176.

Third, Appellant-States' interpretation should be adopted because it "furthers rather than obstructs [HIPF's] purpose." *Id.* at 63. The "political argument . . . in favor of this tax was that insurance companies [would] make money from increased enrollment due to the ACA, and therefore should pay more to the federal government." ROA.1617. Leaving aside that the ACA increased States' burdens, States could not have participated in this windfall because they do not sell insurance. Requiring them nonetheless to pay the HIPF would place the cost precisely where Congress did not want it—taxpayers.

II. The Federal Courts Have Jurisdiction to Award Appellant-States Relief.

Throughout this litigation, the United States has sought to avoid an inquiry into the legality of its actions by raising a flurry of baseless jurisdictional objections. It has wisely dropped many of these arguments on appeal. To avoid burdening the Court with potentially unnecessary briefing, Appellant-States will focus on the arguments

[8] For the mathematically inclined, under Section 9010(b)(1), even without the exception, the obligation of a State using a fee-for-service model would be calculated:

$$HIPF\ obligation = \frac{State\ premiums}{total} = \frac{0}{total} = 0$$

that the United States does challenge, namely that: (1) Appellant-States lack standing because Congress caused their harm, and therefore it is not redressable by eliminating the Certification Rule; and (2) their claims fall outside the APA's waiver of sovereign immunity because they are time barred and request for monetary relief. These assertions are meritless.[9]

A. States have standing to challenge taxes levied against them.

Throughout the trial-court proceedings, the United States argued that Appellant-States lack standing because (among other reasons) any injury they may have suffered was self-inflicted, on the theory that States could avoid the HIPF by (1) transitioning to a fee-for-service model, or (2) using their supposed market leverage to negotiate for MCOs to bear the cost of the HIPF. ROA.111-17, 225-27, 3308-33. As amici explain, the structure of the Medicaid-MCO market is such that the Certification Rule *requires* that the HIPF be passed on to States. *E.g.*, Medicaid Health Plans Br. 10. So the United States changes tactics and makes two new, equally baseless arguments.

First, it asserts (at 23-24) that States suffered no injury due to the Certification Rule because Congress imposed the HIPF. For the reasons discussed above, that contention is belied by the ACA's language.

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[9] Recognizing that ordinary rules of waiver do not apply to jurisdictional questions, Appellant-States refer the Court to their briefing in the district court on these now-dropped arguments, ROA.253-63, 3779-91, and ask to submit supplemental briefing should the Court have further questions. *Cf. Hernandez v. Garcia Peña*, 820 F.3d 782, 786 n.3 (5th Cir. 2016) (acknowledging rules regarding full briefing apply "more leniently" to appellees).

Second, the United States asserts (at 24-25)—again for the first time—that Appellant-States conceded their Certification-Rule claims are not redressable when they filed a lawsuit challenging the IRS's effort to impose the HIPF in 2018 through a separate regulation combined with the statutory actuarial-soundness requirement. *See also* Medicaid Health Plans Br. 12-19. States are "entitled to special solicitude in . . . standing analysis," *Massachusetts v. EPA*, 549 U.S. 497, 520 (2007), particularly when that analysis turns on questions of redressability, Ernest A. Young, *State Standing and Cooperative Federalism*, 94 NOTRE DAME L. REV. 1893, 1921-24 (2019). So long as Appellant-States can show that a favorable ruling against a federal agency would redress any *part* of their injury, that is sufficient. *Compare Cramer v. Skinner*, 931 F.2d 1020, 1028 (5th Cir. 1991), *with Inclusive Cmtys. Project, Inc. v. Dep't of Treasury*, — F.3d —, No. 19-10377, 2019 WL 7287546, *4 (5th Cir. Dec. 30, 2019).

The United States has never contested that the Certification Rule was the sole basis by which the HIPF was imposed on the States during the tax years at issue in this lawsuit. "If that rule is declared unconstitutional, as [Appellant-States] have requested," then Appellant-States cannot lose Medicaid funding for refusing the pay the HIPF "by virtue of that rule." *Larson*, 456 U.S. at 242. The fact that the IRS seeks to apply the fee through a different rule in a different year is a different harm that may be redressed in a different lawsuit or through different claims. *Id.* at 242-43; *see also Dep't of Tex., Veterans of Foreign Wars of the U.S. v. Tex. Lottery Comm'n*, 760 F.3d 427, 432-33 (5th Cir. 2014) (en banc). It does not deprive Appellant-States of standing to challenge HHS's use of the Certification Rule and ASOP 49 to impose a tax on States from which they were exempt. *Larson*, 456 U.S. at 242-43. If it were

otherwise, the federal government could always dream up *additional* ways to burden a plaintiff, multiply the plaintiff's injuries, and then claim there is no injury to be redressed at all.[10]

B. The case falls within the APA's waiver of sovereign immunity.

1. Appellant-States' claims are timely.

Nor are Appellant-States barred from bringing this challenge by the fact that the United States sought to impose a 2010 tax through a 2002 rule. As will be discussed below (at IV.C), the relevant rule here was adopted in 2015 when HHS began to apply ASOP 49 as a mandatory rule of construction. That rule falls easily within the six-year limit imposed by the APA. 28 U.S.C. § 2401(a).

But even assuming the relevant starting point was 2002, as the United States acknowledges (at 25-26), "an agency's application of a rule" restarts the clock "to challenge the agency's constitutional or statutory authority." *Dunn McCampbell*, 112 F.3d at 1287. The aggrieved party simply may no longer challenge the procedures by which the rule was originally adopted. *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); *Texas*, 749 F.2d at 1146.

Appellant-States' claims are timely because they are not challenging the process by which the Certification Rule was adopted in 2002. They are challenging the validity of applying that rule in 2015 following the ACA's changes to Medicaid in 2010. Courts recognize that "[a] plaintiff cannot be expected to anticipate all possible

[10] The district court also did not award the States the full relief they sought, which would have fully redressed their harm. For the reasons Appellant-States explain below, this was error.

future challenges to a rule and bring them within six years of the rule's promulgation, before a later agency action applying the earlier rule leads to an injury." *Cal. Sea Urchin Comm'n v. Bean*, 828 F.3d 1046, 1049-50 (9th Cir. 2016) (citing *Bennett v. Spear*, 520 U.S. 154, 178 (1997)). Indeed, because the HIPF did not exist, and there was no binding definition of "actuarial soundness" applicable to Medicaid MCOs until 2010, ROA.3087, any challenge to the Certification Rule would not have been ripe. *See Lopez v. City of Houston*, 617 F.3d 336, 341-42 (5th Cir. 2010).

The district court correctly concluded that the agency applied the Certification Rule to Appellant-States less than six years before Appellant-States sued. To determine if there is a final agency action applying an earlier regulation, the court looks to whether an action (1) "mark[s] the consummation of the agency's decisionmaking process," and (2) is one "by which rights or obligations have been determined." *U.S. Army Corps of Engr's v. Hawkes Co.*, 136 S. Ct. 1807, 1813 (2016) (quotation marks omitted). Those obligations must be legally binding; practical pressure to comply is insufficient. *Louisiana v. U.S. Army Corps. of Eng'rs*, 834 F.3d 574, 583 (5th Cir. 2016).

In this case, under guidance issued by HHS, States still had the legal option to exclude the HIPF from capitation rates in their contracts with MCOs as late as 2013. ROA.2592 (stating only that "[t]he potential effect[s] of the fee may be considered"). As the United States's own authority demonstrates, however, HHS "approved regulations [in 2015] that aim[ed] to eliminate previous ambiguities around actuarial soundness." Mendelson, *supra*, at 274. Among other things, those changes included that HHS formally began applying ASOP 49 as the binding standard

applicable to States through the Certification Rule. ROA.3243. Even more directly, in 2015, Appellant-States' MCO contracts were required to include the HIPF in their capitation rates. ROA.297-301. Until then, any action involving the HIPF carried no legal consequence, meaning that there was no final agency action, and the statute of limitations had not yet begun to run. *Louisiana*, 834 F.3d at 584.

2. The district court properly awarded equitable disgorgement.

a. The equitable relief of disgorgement is not the legal relief of "money damages."

Because the legal consequence of the Certification Rule was that the IRS has funds belonging to Appellant-States by statute, the district court had jurisdiction to order equitable disgorgement. In the APA, Congress generally waived sovereign immunity for suits challenging illegal agency actions "seeking relief other than money damages." 5 U.S.C. § 702. Courts may not, as the United States requests, "substitute the words 'monetary relief' for the words 'money damages' actually selected by Congress." *Bowen*, 487 U.S. at 896. Instead, because Congress was trying to limit the use of sovereign immunity to avoid legitimate claims, "'money damages' is narrowly construed." *Philips Petrol. Co. v. Johnson*, No. 93-1377, 1994 WL 484506, *1 (5th Cir. Sept. 4, 1994) (citing *Bowen*, 487 U.S. at 893); *see also, e.g.*, *MBank New Braunfels N.A. v. FDIC*, 772 F. Supp. 313, 318 (N.D. Tex. 1991) (citing *Tex. Am. Bancshares v. Clark*, 740 F. Supp. 1243, 1248 (N.D. Tex. 1990); *accord Armendariz-Mata v. U.S. Dep't of Justice*, 82 F.3d 679, 682 (5th Cir. 1996). Suits seeking "judicial review of claims for specific relief that result in the payment of money" may proceed

"because such actions are not for 'money damages.'" *St. Tammany Par. ex rel. Davis v. FEMA*, 556 F.3d 307, 317-18 (5th Cir. 2009).[11]

Bowen v. Massachusetts, 487 U.S. 879 demonstrates why Appellant-States' request for equitable disgorgement is a claim for specific relief afforded by Medicaid, not a claim for "money damages." In that case, as here, a State sought funds wrongfully withheld by HHS under Medicaid. The Supreme Court considered the history and language of the APA as well as the traditional meaning of the term "money damages," *id.* at 893-900, and determined that "grant-in-aid programs," such as Medicaid "were expressly" among those claims over which Congress "wanted to be sure" to waive sovereign immunity. *Id.* at 898. Therefore, the Court unambiguously held, "Congress intended to authorize equitable suits for specific monetary relief" for funds guaranteed by statute "as [the Court] defined that category." *Id* at 899-900.

The United States asserts (at 43-44) that this is not a suit for specific monetary relief because the IRS cannot return the exact same dollars it received from States through the MCOs. Had the IRS physically seized Appellant-States' cash, that might have been a valid objection under certain circumstances. *Compare Bailey v. United States*, 508 F.3d 736, 740 (5th Cir. 2007), *with United States v. Minor*, 228 F.3d 352, 355-56 (4th Cir. 2000). That does not, however, create a "world in which no challenge to [the IRS's] actions is ever outside the closed loop of its taxing authority."

[11] The Court need not reach the issue, but as will be discussed in Part VI, Congress also waived immunity for tax claims under 28 U.S.C. § 1346(a)(1).

Cohen v. United States, 650 F.3d 717, 726 (D.C. Cir. 2011) (en banc). Instead, Appellant-States would have had claims for wrongful levy, rather than the APA. 26 U.S.C. § 7426. Because this case involves Appellant-States' right to funds under Medicaid, the APA was the appropriate recourse. *Bowen*, 487 U.S. at 900.

Indeed, in *Bowen* itself, the Court recognized that Medicaid functions through "a series of huge quarterly advance payments that are based on the State's estimate of its anticipated future expenditures"—not specific transfers based on specific services. 487 U.S. at 883-84. Nevertheless, the absence of specific, identifiable currency that was taken from the Massachusetts that could be returned did not transform Massachusetts's claim into one for "money damages." Instead, the only question was whether the requested relief would have placed the monetary burden where it "'should have [been] all along and would have [been] in the first instance'" had the agency complied with federal law. *Id.* at 894 (quoting *Sch. Comm. of Burlington v. Dep't of Educ. of Mass.*, 471 U.S. 359, 370-71 (1985)).

For the reasons discussed above, the text of the ACA places the burden of the HIPF on businesses that sell health insurance, not States. Because States were not supposed to bear this financial burden, Congress has waived sovereign immunity to allow them to seek return of their funds. *Linea Area Nacional de Chile SA v. Meissner*, 65 F.3d 1034, 1043-44 (2d Cir. 1995) (adopting *Zellous v. Broadhead Assocs.*, 906 F.2d

94 (3d Cir.1990)); *Md. Dep't of Human Res. v. HHS*, 763 F.2d 1441, 1446 (D.C. Cir. 1985).[12]

b. Because the ACA exempted States from paying the HIPF, the district court had discretion to order equitable disgorgement.

The United States's closely related merits argument that equitable disgorgement was an inappropriate exercise of the district court's remedial discretion fails for the same reasons. The United States does not dispute that if Appellant-States' harm related to the Certification Rule, disgorgement would have been appropriate on the merits. *All State Ins. Co. v. Receivable Fin. Co.*, 501 F.3d 398, 413 (5th Cir. 2007). Indeed, in the ordinary course, disgorgement "requires that the defendant give up 'those gains . . . properly attributable to the defendant's interference with the claimant's legally protected rights.'" *Kokesh v. SEC*, 137 S. Ct. 1635, 1640 (2017) (quoting *Restatement (Third) of Restitution and Unjust Enrichment* § 51, cmt. a (2010)). The United States simply claims (at 41-42) that Appellant-States' harm was not caused by the Certification Rule.

To the extent the United States is asserting that Congress imposed the HIPF on States, it fails (once again) for the reasons discussed above.

[12] For similar reasons, Appellant-States should have been awarded interest. When parties are awarded specific monetary relief under Section 702, the better view is that interest on those funds is part of the returned property. *United States v. $515,060 U.S. Currency*, 152 F.3d 491, 505 (6th Cir. 1998); *United States v. $277,000 U.S. Currency*, 69 F.3d 1491, 1493 (9th Cir. 1995). *But see Smith v. Principi*, 281 F.3d 1384, 1388 n.2 (Fed. Cir. 2002) (acknowledging circuit split).

To the extent the United States is asserting that Appellant-States' harm traces to the original actuarial-soundness requirement from 1981, that ignores the impact of ASOP 49. Until the adoption of ASOP 49, the only guidance for actuarial soundness specific to Medicaid MCOs provided a non-binding list of factors that actuaries *could* consider. Other binding guidance made clear, however, that actuaries must comply with federal law. ROA.3186. Because federal law exempted States from the HIPF, this earlier guidance would have permitted an actuary to *consider* the HIPF, but he could not have forced an unwilling State to pay the HIPF. ASOP 49, by contrast, requires the actuary to account for any non-deductible, IRS-mandated taxes—regardless of whether Congress exempted States from paying those taxes. ROA.1864-65. The Certification Rule makes this standard federal law, 42 C.F.R. § 438.6, and thus causes Appellant-States' injury.

III. The Certification Rule Violates the Nondelegation Doctrine.

Because the Certification Rule purported to make a private agency's standard binding federal law, the district court correctly held that it violated the principle that Congress may not delegate the authority vested in it by Article I. Our system of government is built around the single, overarching principle that "[t]he accumulation of all powers, legislative, executive, and judiciary, in the same hands . . . may justly be pronounced the very definition of tyranny." THE FEDERALIST No. 47, at 298 (Madison) (C. Rossiter, ed. 1961). To protect against such accumulation of power, the Constitution vests "All legislative Powers [t]herein granted" in Congress. U.S. CONST. art. I, § 1. And the Supreme Court has long held that "Congress . . . may not transfer to another branch 'powers which are strictly and exclusively legislative.'"

Gundy v. United States, 139 S. Ct. 2116, 2123 (2019) (quoting *Wayman v. Southard*, 23 U.S. (10 Wheat.) 1, 42-43 (1825)). Congress violated this principle when it purported to allow the Executive to dictate the conditions under which States may receive Medicaid funding, and the fault was compounded when that role passed to a private entity.

A. Congress's actuarial-soundness requirement is constitutionally problematic.

Congress's decision to condition States' receipt of Medicaid funds on meeting an entirely undefined standard like actuarial soundness is itself problematic under the nondelegation doctrine. Since the Founding, legislative power has been defined as the power to "prescrib[e] the rules by which the duties and rights of every citizen are to be regulated." THE FEDERALIST No. 78, at 464 (Hamilton); *Fletcher v. Peck*, 10 U.S. (6 Cranch) 87, 136 (1810) (defining it as the power to "prescribe general rules for the government of society"). Congress may allow the Executive, which is vested with its own power to execute the law, to fill in the details of how a statute functions on a-day-to-day basis, *Gundy*, 139 S. Ct. at 2129, or to find that the law has been triggered by "certain fact[s] being established," *Miller v. Mayor of N.Y.*, 109 U.S. 385, 393 (1883). But Congress may *not* allow the Executive to "pass a prohibitory law." *Panama Refin. Co. v. Ryan*, 293 U.S. 388, 414415 (1935); *A.L.A. Schechter Poultry*, 295 U.S. at 537-38. This distinction is between delegation of power "to make the law, which necessarily involves a discretion as to what it shall be," and conferring discretion to execute the law as it currently is. *Marshall Field & Co. v. Clark*, 143 U.S. 649, 693-94 (1892).

Because applying the law involves some degree of interpreting it, this line is necessarily fuzzy, and some commentators have questioned whether it even still exists. Jason Iuliano & Keith E. Whittington, *The Nondelegation Doctrine: Alive and Well*, 93 NOTRE DAME L. REV. 619, 623-26 (2017). A majority of the Supreme Court has, however, confirmed within the last year that the doctrine is alive, well, and applicable at least where "the statute lacks a discernible standard," *Gundy*, 139 S. Ct. at 2131 (Alito, J., concurring), and possibly more broadly, *id.* at 2131 (Gorsuch, J., dissenting) (writing for C.J. Roberts and J. Thomas); *Paul v. United States*, 140 S. Ct. 342, 342 (2019) (Kavanaugh, J., statement regarding the denial of certiorari).

The actuarial-soundness requirement lacks any discernible standard limiting the Executive's discretion. Unlike other vague standards that have been upheld, the "boundaries of [the executive's] authority" are not defined elsewhere in the statute, *Gundy*, 139 S. Ct. at 2129, customary practice, *Whitman v. Am. Trucking Ass'ns.*, 531 U.S. 457, 472-73 (2001), or common law, *cf. A.L.A. Schechter Poultry*, 295 U.S. at 531-32. The Board did not adopt the first ASOP until 1986, five years after the requirement was enacted.[13] It did not define "actuarial soundness" for any purpose until 1996, and even then that definition was not applicable to Medicaid-MCO contracts.[14]

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[13] Board, *Nonguaranteed Charges or Benefits for Life Insurance Policies and Annuities Contracts*, ASOP No. 2 (2013), https://www.actuarialstandardsboard.org/wp-content/uploads/2013/12/asop002_171.pdf (re-designating ASOP No. 1).

[14] Board, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*, ASOP No. 26 (1996) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop026_052.pdf.

Indeed, the Certification Rule was adopted in 2002 because even more than two decades after the creation of the statutory actuarial-soundness requirement, neither actuaries nor HHS could create "prescriptive standards" to define what "actuarially sound" meant. ROA.1411. The Board still did not define actuarial soundness in the context of Medicaid MCOs until 2015, after HHS demanded a response "in reaction to the [GAO]," ROA.3162, who had criticized the Board's lack of a working definition, ROA.3087. It is hard to imagine a clearer example of when Congress "has overstepped the[] limitations" of Article I by choosing not to "establish[] the standards of legal obligation," but instead "to transfer that function to others." *A.L.A. Schechter Poultry*, 295 U.S. at 530; *Whitman*, 531 U.S. at 472-76 (adopting narrowing interpretation to avoid nondelegation problem).

It is no response to say that defining actuarial soundness was not practicable in 1981 due to the technical nature of the question. "Our Constitution, by careful design, prescribes a process for making laws," with "many accountability checkpoints." *Amtrak*, 575 U.S. at 61 (Alito, J., concurring) (citing *INS v. Chadha*, 462 U.S. 919, 959 (1983)); *see also Loving v. United States*, 517 U.S. 748, 757-58 (1996) ("Article I's precise rules of representation, member qualifications, bicameralism, and voting procedure make Congress the branch most capable of responsive and deliberative lawmaking."). If Congress could do no better than to "l[eave] the matter to the President . . . to be dealt with as he pleased," then Congress could not condition States' receipt of Medicaid funds on MCOs having actuarially sound capitation rates. *Panama Refining Co.*, 293 U.S. at 418.

B. Article I does not permit private parties to impose a tax on States.

The Court need not address the general standards for the nondelegation doctrine, however, because the Certification Rule violates the more strictly policed private nondelegation doctrine. As Justice Alito has explained, the "formal reason" why the Court has not "enforce[d] the nondelegation doctrine with more vigilance is that other branches of Government have vested powers of their own that can be used in ways that resemble lawmaking." *Amtrak*, 575 U.S. at 61. "When it comes to private entities, however, there is not even a fig leaf of constitutional justification." *Id.* at 62. "[P]ower conferred" on one private entity to regulate another has been called "delegation in its most obnoxious form." *Carter*, 298 U.S. at 311 ("[O]ne person may not be [e]ntrusted with the power to regulate the business of another, and especially of a competitor."). But Justice Sutherland does not appear to have even contemplated this scenario when he penned those words. If a private party regulating a private party is constitutionally "most obnoxious," *id.*, authorizing a private entity to regulate a sovereign State is constitutionally repugnant. The United States makes six arguments why this delegation is nonetheless permissible. None has merit.

First, the United States asserts (at 30-32) that *Currin v. Wallace*, 306 U.S. 1 (1939), and *United States v. Rock Royal Co-op*, 307 U.S. 533 (1939), permit the Board to create law governing contracts entered by States because it is disinterested. The United States overreads the holdings of these cases and conflates two limits on Congress's ability to utilize the services of private entities: the nondelegation doctrine and due process. Though the limits can arise in the same cases, the "[n]on-delegation doctrine is structural and seeks to ensure that Congress makes the important

decisions." Alexander Volokh, *The New Private-Regulation Skepticism: Due Process, Non-delegation and Antitrust Challenges*, 37 HARV. J. L. & PUB. POL'Y 931, 974 (2014). By contrast, "[d]ue process . . . is all about fairness. Fairness and structural boundaries may be related, but not in any necessary way." *Id.*

The only limit at issue in this case is the first, which recognizes that not all ways that governments employ private parties are created constitutionally equal. *See* Harold I. Abramson, *A Fifth Branch of Government: The Private Regulators and their Constitutionality*, 16 HASTINGS CONST. L. Q. 165, 169-74 (1989) (categorizing traditional use of private actors in government). Under the nondelegation doctrine, Congress may condition the effect of its legislation on the acquiescence of disinterested groups of affected private parties as it did in *Currin*, 306 U.S. at 15, and *Rock Royal*, 307 U.S. at 545-46. It may also "employ private entities for *ministerial* or *advisory* roles," but it may *not* give binding "governmental power over others" to such a party even if that party is disinterested. *Pittston Co. v. United States*, 368 F.3d 385, 395 (4th Cir. 2004) (citing *United States v. Frame*, 885 F.2d 1119, 1129 (3d Cir. 1989)).

Private parties' roles in giving content to and applying the Certification Rule exceed the scope of permissible delegation to a private party because they are formulating, and making binding decisions about the applicability of, rules governing States' access to Medicaid funds. *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1488 (9th Cir. 1992) (approving delegation because agency actor "retains ultimate authority to issue the regulation") (citing *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 399 (1940)); *Cospito v. Heckler*, 742 F.2d 72, 89 (3d Cir. 1984) (application of accreditation standards). As the United States points to no instance in which HHS

can overturn the private decisions required by the Certification Rule, the rule violates the nondelegation doctrine. *Cospito*, 742 F.2d at 89.

Had the Board been an interested party, Appellant-States might have argued that due process prevents Congress even from conditioning its law on the Board's approval. *See Wash. ex rel. Seattle Title Tr. Co. v. Roberge*, 278 U.S. 116, 121 (1928); *Eubank v. Richmond*, 226 U.S. 137, 143 (1912). But as Appellant-States brought no such claim, its viability is irrelevant here.

Second, the United States makes a related argument (at 34-35) that the district court improperly relied on the supposed timing of the certification of Appellant-States' contracts. Specifically, the United States asserts (at 34) that it should make no difference whether private actors can retrospectively "veto" the applicability of a rule (as the Court approved in *Currin*) or prospectively "certify" compliance with a rule (as actuaries do here). This too conflates two separate issues: the Board's adoption of binding rules defining "actuarial soundness" and an actuary's later certification of compliance with those standards. Disentangling the different actions taken by private entities in this case helps show why this argument is a red herring.

The Board's role in setting actuarial standards is unlawful because it is a private entity defining the content of a federal law as it applies to someone else. ROA.1695 ("No outside body dictates the content of ASOPs."). Such rule-making necessarily occurs before HHS can assess any particular contract. It is nonetheless unconstitutional because the Board is formulating the rules, not merely determining the existence of a condition under which the law will apply. *A.L.A. Schechter Poultry*, 295 U.S.

at 533-34; *see also Gundy*, 139 S. Ct. at 2135-37 (Gorsuch, J., dissenting) (discussing significance of formulation/condition distinction in Court's jurisprudence).

The certification decisions of individual actuaries are separately problematic but not because of the order in which the decisions occur. They are problematic because HHS "must review and approve" all MCO contracts under which payments are "actuarially sound," meaning that they have "been certified . . . by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established" by the Board. 42 C.F.R. § 438.6(a),(c)(2)(i). The regulations do not preserve for HHS the right to approve a contract where an actuary refuses certification. This contrasts with the cases on which the United States relies where the relevant agency maintained the ability to reverse the private entity's decision—regardless of the order in which they were made. *See, e.g.*, *Cook v. Oschner Found. Hosp.*, 559 F.2d 968, 975 (5th Cir. 1977).

Particularly ill-founded is the reliance on cases where Congress has conditioned the applicability of federal law on the acquiescence of States. *E.g.*, *Confederated Tribes of Siletz Indians of Or. v. United States*, 110 F.3d 688 (9th Cir. 1997). Such conditional legislation is part and parcel of cooperative federalism, where changes to federal policy will often necessitate changes to state law (assuming States choose to remain in the program). *See* Young, *supra*, at 1903-05. As will be discussed below, Congress "cannot compel the States to enact or enforce a federal regulatory program" or "conscript[] the State's officers directly." *Printz v. United States*, 521 U.S. 898, 935 (1997). Therefore, Congress conditioning its laws on approval by state officials is

different in kind from allowing a private entity to make final determinations about compliance with federal law.

Third, the United States asserts (at 32-33) that delegation to the Board was appropriate because defining actuarial soundness is highly technical. Again, this ignores that there are ways to employ the expertise of private entities without allowing them to define federal law. Abramson, *supra*, at 170-73. Congress may instruct agencies to consider standards set by private entities when addressing a technical question. *Cf. Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 95-96 (1995). But the Certification Rule crosses the line when it allows a private entity to exercise binding "governmental power over others." *Pittston Co.*, 368 F.3d at 395.

Fourth, the United States asserts (at 37-39) that the Rule is "nothing particularly novel" because "[n]umerous federal statutes require private parties to comply" with standards set by private parties. As an initial matter, "historical practice . . . 'does not, by itself, create power.'" *Texas v. United States*, 809 F.3d 134, 184 & n.193 (5th Cir. 2015) (quoting *Medellin v. Texas*, 552 U.S. 491, 532 (2008)). But a closer look at the cited provisions demonstrates that the Board's role here *is* novel. For example, the United States relies primarily (at 37) on securities regulations that reference generally accepted accounting principles ("GAAP") as defined by the American Institute of Certified Public Accountants (or, more precisely, by the Financial Accounting Standards Board). However, the Securities Exchange Commission uses GAAP as a *guide* to determine whether a company's financial statements would mislead an average investor because investors use GAAP. *Omnicare, Inc. v. Laborers Dist. Council Const. Indus. Pension Fund*, 575 U.S. 175, 188 (2015). Other agencies consider

GAAP for similar purposes. *Shalala*, 514 U.S. at 97. Failure to comply with GAAP does not by itself lead to liability for securities fraud. *Ind. Elec. Workers' Pension Tr. Fund IBEW v. Shaw Grp., Inc.*, 537 F.3d 527, 534 & n.3 (5th Cir. 2008) (collecting cases).

Most of the United States's other examples suffer the same problem: they are non-binding, 15 U.S.C. §§ 2224-26 (creating non-binding list of approved locations for federal conferences), or are merely designed to promote comparability of information, *id.* § 272(b) (defining duties of "the President's principal advisor on standards policy"). The only exception is that under certain circumstances a private entity can set federal toy-safety standards. *Id.* § 2056b. Far from showing a widespread practice, the United States's reliance on this inconsequential regulation demonstrates that the Board's role in defining federal law here is unique.

Fifth, the United States argues that if the Court accepts Appellant-States' view of nondelegation, it will need to strike down numerous state laws. Once again, Appellant-States' claim derives "federal separation-of-powers concerns that cannot dictate how state governments allocate their powers." *Boerschig v. Trans-Pecos Pipeline, L.L.C.*, 872 F.3d 701, 707 (5th Cir. 2017). Individual States may—or may not—have language in their own Constitutions that similarly bars their state legislatures from delegating lawmaking powers. (Texas, for its part, has a robust private nondelegation doctrine; Mississippi, less so. Volokh, *supra*, at 963-70.) But what state Constitutions say about state governments is simply irrelevant to whether the U.S. Constitution permits the delegation the United States has attempted here.

Finally, the United States argues (at 33-34) that the HIPF does not implicate delegation concerns because it is a condition on federal spending under Medicaid. This is contrary to what the United States has argued for years—that the HIPF is *not* a condition on Medicaid. *E.g.*, ROA.3323-24, 4216-17; *see also* ROA.4018 (accepting that argument). Though Appellant-States certainly agree that the HIPF is properly considered a condition on spending (*infra* V.A), the conclusion the United States seeks to draw depends on the additional premise that Appellant-States' have asserted a due-process-type nondelegation claim. U.S. Br. 34. Appellant-States' claim instead derives from the separation of powers rooted in the Vesting Clauses of Articles I, II, and III of the Constitution. *See Amtrak*, 575 U.S. at 67 (Thomas, J., concurring); *Boerschig*, 872 F.3d at 707. The Vesting Clause in Article I applies to all of Congress's powers—including its taxing and spending authority. *See* U.S. CONST. art. I, § 8 (enumerating both powers).

Because the Certification Rule attempts to delegate Congress's legislative power to prescribe the rules by which States' MCO contracts are judged as well as the power to certify compliance with those rules to a private entity, the district court correctly declared it to be unconstitutional.

IV. The Certification Rule Also Violates the APA.

The district court erred, however, when it held that the Certification Rule was substantively and procedurally valid under the APA. The court rejected Appellant-States' claim that the rule exceeded HHS's statutory authority on the grounds that the States had (1) not challenged Congress's delegation of the authority to define actuarial soundness, ROA.4012 n.49, and (2) conceded that the Certification Rule

was reasonable in 2002, ROA.4015.[15] The district court also rejected Appellant-States' procedural claims because the Certification Rule had gone through notice-and-comment rulemaking in 2002. ROA.4014. Each step of the district court's analysis was wrong.

A. The district court erred by focusing entirely on the Certification Rule's legality in 2002.

The district court's analysis of both the State's substantive and procedural claims stumbles out of the gate when it focuses entirely on what happened in 2002. Appellant-States do not dispute that the Court should examine the basis for agency's action based on its reasoning and the law in effect when that action was taken. *E.g.*, *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2573 (2019). But as the district court acknowledged in addressing timeliness, the final agency actions at issue occurred in 2015, not 2002. When Congress substantively amends the statutory scheme that forms the basis of a regulation, this Court must assess the agency's actions under current law. *See Miss. Poultry Ass'n, Inc. v. Madigan*, 31 F.3d 293, 307-08 (5th Cir. 1994) (en banc); *Isaacs v. Bowen*, 865 F.2d 468, 473 (2d Cir. 1989) (discussing *United States v. Bd. of Comm'rs*, 435 U.S. 110, 132 (1978)). The district court thus should have considered both the impact of the ACA in 2010 and ASOP 49 in 2015.

[15] The district court correctly concluded that HHS's interpretation of the HIPF exceeded its statutory authority because it ran afoul of the non-delegation doctrine. ROA.4014. As the United States has not briefed any challenge to this statutory ruling, any such appeal is forfeited under Federal Rule of Appellate Procedure 28(a)(8).

This error appears to animate the district court's conclusion (ROA.4012 n.49) that Appellant-States did not challenge the term "actuarially sound" as a delegation. Appellant-States did not challenge whether Congress delegated authority to define that term in 2002, but Appellant-States did challenge whether Congress continued to delegate that ability in 2010 under the historic-importance doctrine. ROA.1563. This doctrine is a modern-day cousin of the nondelegation doctrine, which though "nominally a canon of statutory construction" used to narrow rather than invalidate statutes, is applied "in service of the constitutional rule that Congress may not divest itself of its legislative power by transferring that power to an executive agency." *Gundy*, 139 S. Ct. at 2141-42 (Gorsuch, J., dissenting); Cass Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 315-16 (2000) (arguing that doctrine "has been relocated" to such canons). The United States has never proposed a narrowing construction here, *supra* n.15, and any such construction would be inconsistent with the statutory text of the Medicaid title of the Social Security Act as amended by the ACA.

B. The Certification Rule exceeds HHS's statutory authority as modified by the ACA.

The Certification Rule exceeded HHS's statutory authority as modified by the ACA. HHS's interpretation stands only if: (1) Congress delegated authority to the agency to answer the "question of deep 'economic and political significance'" of whether States must pay the taxes imposed by the ACA, *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015); (2) Congress did not specifically speak to the question of who pays the HIPF, *City of Arlington v. FCC*, 569 U.S. 290, 307 (2013); and (3) "the

agency's answer [to that question] is based on a permissible construction of the statute," *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 843 (1984). To the extent that the Certification Rule interprets actuarial soundness to impose the HIPF on States, it fails at each step.

1. *Chevron "Step 0"*: Congress did not grant any agency the power to determine to whom the HIPF applies. An agency's ability to promulgate regulations is "premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000). Under the historic-importance doctrine, that presumption does not apply in landmark legislation addressing issues of great public concern. *Util. Air Regulatory Grp. v. EPA*, 537 U.S. 302, 324 (2014). The doctrine applies with particular force "[w]here an administrative interpretation of a statute invokes the outer limits of Congress' power," *Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 172 (2001), or threatens to upset the balance between national and state government, *cf. Bond v. United States*, 572 U.S. 844, 858 (2014).

The ACA is precisely the type of "monumental piece of . . . legislation that regulates a huge swath of this nation's economy," to which the historic-importance doctrine applies. *Texas*, 945 F.3d at 368; *King*, 135 S. Ct. at 2489. Indeed, it has rightly been described as "one of the most consequential laws ever enacted by Congress." *Sissel v. U.S. Dep't of HHS*, 799 F.3d 1035, 1049 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from denial of rehearing en banc).

Highly controversial from its inception, "Congress wrote key parts of the Act behind closed doors, rather than through 'the traditional legislative process.'" *King*, 135 S. Ct. at 2492 (quoting Cannan, *supra* n.5, at 163). Due to its enormous costs, revenue provisions were particularly scrutinized. *E.g.*, Cannan, *supra* n.5, at 145-46. This Court "must be guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency." *Texas*, 809 F.3d at 181. Having at times made significant changes to the ACA to "please a single senator" threatening to "derail" the bill, Cannan, *supra* n.5, at 154-56, it is "highly unlikely that Congress would leave the determination" of the target of the ACA's taxes "to agency discretion—and even more unlikely that it would achieve that through" a rule interpreting a statute passed in the 1980s, *MCI Telecomm. Corp. v. AT&T*, 512 U.S. 218, 230-31 (1994). Without such a delegation, HHS's action fails.[16]

2. *Chevron Step 1*: For many of the same reasons, the Certification Rule exceeds what statutory authority HHS does exercise because it fails to "give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 843. The district court erred in focusing entirely on the actuarial-soundness requirement in 42 U.S.C. § 1396b(m)(2)(A)(iii). ROA.4003, 4012-14. Courts must look to the entirety

[16] Amici's assertion that the ACA ratified HHS's interpretation by making an unrelated reference to actuarial soundness proves the opposite. Blue Cross Br. 16. Basic principles of statutory interpretation require terms be given consistent meanings. SCALIA & GARNER, *supra*, at 170-73. That Congress referenced actuarial soundness in the same statute that exempted States from the HIPF implies that Congress did not think the requirement imposed HIPF on the States.

of the statutory scheme to determine whether a State's liability for the HIPF is a "question[] left open by Congress." *Util. Air. Regulatory Grp.*, 573 U.S. at 327 (citing *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 462 (2002)). In schemes like Medicaid, this can require the Court to sort through many interlocking provisions, but ultimately courts "*must* not . . . outsource their constitutionally assigned interpretive duty to Article II agencies when the Article I Congress has spoken clearly." *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 228 (5th Cir. 2019). As discussed above, Congress has, in fact, "established a clear line," which "the agency cannot go beyond." *City of Arlington*, 569 U.S. at 307. That line is that States are exempt from the HIPF. ACA § 9010(c)(2)(B).

3. *Chevron Step 2*: At minimum, it was arbitrary and capricious for HHS to continue to apply the Certification Rule as created in 2002 without considering the impact of Section 9010. Though the scope of arbitrary-and-capricious review is "narrow," the Court must overturn an agency action that did not "examine[] the relevant data and articulate[] a satisfactory explanation for [its] decision." *Dep't of Commerce*, 139 S. Ct. at 2559 (quotation marks omitted). Failure to consider obvious policy alternatives or changed factual circumstances can render a decision arbitrary. *Cf. Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 46-51 (1983); *Smiley v. Citibank (S.D.) N.A.*, 517 U.S. 735, 739-42 (1996). In 2002, HHS refused to adopt more specific guidance because it presumed that analysis of MCO contracts under the Certification Rule would be "based upon concepts of predictability and reasonableness." ROA.473.

But the HIPF was not predictable in 2002. *Cf.* ROA.1797, 2633, 2754. Other federal taxes imposed on Medicaid MCOs were minor and applied across industries (*e.g.*, FICA). By contrast, the HIPF is an unprecedented, multi-billion-dollar assessment directly on healthcare premiums. ROA.2754. Moreover, because it is non-deductible, the HIPF is effectively treated as profit for income tax purposes. ACA § 9010(f). It was arbitrary for HHS to run the consequences of such a tax through the Certification Rule without considering this "important aspect of the problem" and offering an "explanation for its decision" that applying the HIPF to States complied with the expressed intent of Section 9010. *Luminant Generation Co., L.L.C. v. U.S. EPA*, 675 F.3d 917, 925 (5th Cir. 2012); *Tex. Office of Pub. Util. Council v. FCC*, 183 F.3d 393, 421-24 (5th Cir. 1999).

C. HHS's adoption of ASOP 49 required notice and comment.

It was also impermissible for HHS to adopt ASOP 49 as a binding rule without notice and comment. The district court again erred when it concluded that the only relevant rule was the certification procedure adopted in 2002. ROA.4014. Because ASOP 49 represents a "statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy," it is a "rule" within the meaning of the APA. 5 U.S.C. § 551(4). An agency "may not cloak its development—and industry-wide application—of a new . . . methodology in the guise of simple adjudicative orders" applying broadly written regulations. *W&T Offshore, Inc. v. Bernhardt*, No. 18-30876, 2019 WL 7042417, at *8 (5th Cir. Dec. 23, 2019); *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019) ("Agencies have never been able to avoid notice and comment simply by mislabeling their substantive

pronouncements."). The only question is thus whether ASOP 49 was a substantive rule, which required notice and comment, or an interpretive rule, which did not. *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979).

Because ASOP 49 creates binding standards on States' MCO contracts and removes discretion that actuaries previously had to approve capitation rates that exclude the HIPF, it was a substantive rule. A rule is "substantive" if it either (1) "affect[s] individual rights and obligations," *Morton v. Ruiz*, 415 U.S. 199, 232 (1974), or (2) does not "genuinely leave[] the agency and its decisionmakers to exercise discretion," *Am. Bus. Ass'n v. United States*, 627 F.2d 525, 529 (D.C. Cir. 1980); *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251-52 (D.C. Cir. 2014) (Kavanaugh, J.).

ASOP 49 does both: Though nominally leaving actuaries some modicum of discretion, the record—including from the United States's own expert (ROA.1683, 1694)—demonstrates that, as a practical matter, there are no longer any circumstances when an actuary may exclude the HIPF from a State's capitation rates. *E.g.*, ROA.1732, 1797, 2072, 2104, 2640, 2700, 2760. And the United States has pointed to no instance where HHS would have discretion to pay States without an actuarial certification. As a result, the adoption of ASOP 49 required Plaintiff-States to pay $479,401,042.24 in just three years. ROA.4676 (reflecting stipulated figures). This is the epitome of a substantive rule requiring notice-and comment rulemaking. *Chrysler*, 441 U.S. at 302. Because no such rulemaking occurred, the district court should have held that ASOP 49 could not be applied against Appellant-States.

V. The HIPF Itself Is Unconstitutional as Applied to States.

The district court also erred in rejecting Appellant-States' claims that Section 9010 itself cannot be applied to Appellant-States. As the United States now acknowledges (at 18-19, 33), the HIPF has been imposed on States as a condition on their receipt of Medicaid funds. Such a condition exceeds Congress's power under the Spending Clause and violates Appellant-States' intergovernmental tax immunity.

A. Imposing the HIPF as a condition on Medicaid funding exceeds Congress's power under the Spending Clause.

The HIPF cannot be enforced against the States (directly or indirectly) as a condition on their receipt of Medicaid funding. The district court rejected this claim on the ground that the HIPF "is an ordinary tax and not a spending condition." ROA.4020. The United States now admits (at 32-33) that this reasoning was wrong and must be reconsidered. Remand, however, is unnecessary because the HIPF violates the Spending Clause as a matter of law.

The Supreme Court has long held that Congress's ability to attach conditions on grants-in-aid to the States has limits. *South Dakota v. Dole*, 483 U.S. 203, 211 (1987). These limits must be enforced with "concern for the federal balance," lest the spending power "obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern, areas which otherwise would lie outside its reach." *NFIB*, 567 U.S. at 675-76 (Scalia, J., dissenting); *see also* THE FEDERALIST No. 33, at 198 (Hamilton). Failure to police these limits, moreover, creates "incentives [that] might lead both federal and state officials to view departures from the

federal structure to be in their personal interests," thereby allowing "each individual official to avoid being held accountable to the voters" for his or her choices. *New York v. United States*, 505 U.S. 144, 182 (1992); *see also Printz*, 521 U.S. at 926-29.

The Supreme Court has identified five specific limits on Congress's spending power: (1) spending must be "in pursuit of the 'general welfare'"; (2) States must have unambiguous notice of any conditions on that spending; (3) any conditions must not be "unrelated 'to the federal interest'" served by the particular spending program; (4) any conditions must not violate some other constitutional provision; and (5) the financial inducement must not cross the line into coercion. *Dole*, 483 U.S. at 207, 211. Medicaid spending is unquestionably in the public interest, but the HIPF violates the remaining limits.

1. *Notice*: Spending legislation functions like a contract. "The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). There "can be no knowing acceptance . . . if a state is unaware of the conditions" imposed. *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 182 (2004). The text of any conditions on federal funds must be unambiguous so that States "clearly understand" to what they are agreeing when they accept federal money. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). Though the Medicaid Act does reserve to Congress the "right to alter, amend, or repeal" its provisions, 42 U.S.C. § 1304, that reservation is limited and "does *not* include surprising participating States with post-acceptance or

retroactive conditions." *NFIB*, 567 U.S. at 584 (quotation marks omitted) (emphasis added).

Neither the Social Security Amendments Act of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) ("Medicaid Act"), nor the ACA gave states clear notice they would have to pay the HIPF as a condition on Medicaid. The actuarial-soundness requirement adopted in 1981 was insufficient because it left "a State's potential obligations under the Act . . . largely indeterminate." *Pennhurst*, 451 U.S. at 24. And, far from placing States on notice of the condition, the ACA exempted all government entities from paying the fee. ACA § 9010(c)(2)(B). Though HHS adopted a policy in 2015 that unambiguously requires States to account for the HIPF, *Congress* has never amended the Medicaid Act to place States on notice that paying this tax for their MCOs is a condition of Medicaid funds.

2. *Improper condition*: Even if States were on notice that the HIPF was a condition on their receipt of further Medicaid funds, the condition was constitutionally improper. Congress may not impose conditions on spending unless they are (a) reasonably related to the purpose for which the funds are being expended, *Dole*, 483 U.S. at 207-08; *Massachusetts*, 435 U.S. at 461, and (b) consistent with other limitations in the Constitution, *e.g.*, *Koontz v. St. John River Mgmt. Dist.*, 570 U.S. 595, 608 (2013); *Tex. Lottery Comm'n*, 760 F.3d at 438. The HIPF violates both principles.

As the Supreme Court explained in *NFIB*, Congress cannot condition receipt of Medicaid funding on a separate funding provision designed to cover the costs of providing coverage to persons made eligible for such services only by the ACA. 567 U.S. at 584-85. The HIPF is such a provision because it pays for, among other things,

tax credits and subsidies so that individuals earning up to 400% of the federal poverty line who are not otherwise eligible for Medicaid can buy health insurance. U.S. GAO, REPORT TO THE RANKING MEMBER, COMM. ON BUDGET, U.S. SENATE: PATIENT PROTECTION AND AFFORDABLE CARE ACT, GAO 13-281, 4-7 (2013) (summarizing costs imposed by ACA). Regardless of the policy merits of such a program, Congress cannot require States to fund it as a condition on Medicaid. *See NFIB*, 567 U.S. at 585.

As will be discussed further below (at V.B), this condition also fails the *Dole* test because it exceeds an independent limit that the Constitution places on the Spending Power: Appellant-States' immunity from federal taxation.

3. *Coercion*: Finally, as with the Medicaid expansion, imposing the HIPF on States impermissibly coerces States to adopt Congress's preferred healthcare policy. As the Supreme Court has repeatedly held, "the Constitution simply does not give Congress the authority to require States to regulate." *NFIB*, 567 U.S. at 522-23 (alterations omitted). Congress can encourage. Congress can incentivize. Congress can even preempt. Congress cannot command. *Murphy v. NCAA*, 138 S. Ct. 1461, 1476 (2018). "That is true whether Congress directly commands a State to regulate or indirectly coerces a State to adopt a federal regulatory system as its own." *NFIB*, 567 U.S. at 578.

Respecting this limitation is "critical to ensuring that Spending Clause legislation does not undermine the status of States" in our federal system, and ultimately the security of the individual. *Id.* at 577. Our "system rests on what might at first seem a counterintuitive insight, that 'freedom is enhanced by the creation of two

governments, not one.'" *Id.* (quoting *Bond v. United States*, 564 U.S. 211, 220-21 (2011)). Conditions on the receipt of funds that "take the form of threats to terminate other significant independent grants" are "properly viewed as a means of pressuring the States to accept policy changes" that might not otherwise be acceptable to those States' citizens. *Id.* at 580. Where the federal government tries to force States to do its bidding in such a manner, "the accountability of both state and federal officials is diminished," rendering individuals without clear recourse to address ill-advised or unpopular policies. *New York*, 505 U.S. at 168; *see also Murphy*, 138 S. Ct. at 1478-79 (listing three ways commandeering States is inconsistent with constitutional framework). And the Constitution prohibits such pressure once States no longer practically have "a 'prerogative' to reject Congress' desired policy." *NFIB*, 567 U.S. at 581-82 (quoting *Dole*, 483 U.S. at 211-12).

Conditioning States' continued receipt of Medicaid funding on paying the HIPF crosses that line. As Chief Justice Roberts has explained, "Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs." *Id.* at 581. Moreover, "States have developed intricate statutory and administrative regimes over the course of many decades" to pursue their healthcare and budgetary policies relating to care for underprivileged citizens through the Medicaid system. *Id.* Threats to the States' ability to receive those funds and run those systems "is much more than 'relatively mild encouragement'" to help Congress fund its policy to expand healthcare coverage to other individuals. *Id.* "[I]t is a gun to the head." *Id.* This is particularly true because a State that decides to *stop* accepting Medicaid dollars is not excused from

shouldering the burden of taxes to support *other* States' Medicaid programs. *Id.* at 672 (Scalia, J., dissenting).

The United States has argued (ROA.3325) that Appellant-States exaggerate the impact of refusing to pay the HIPF because doing so would impact only particular MCO contracts. This is a distinction without a difference because, as the record demonstrates, Appellant-States receive most of their Medicaid reimbursement from MCOs that are subject to the HIPF. For example, all MCOs available to contract with Nebraska are subject to the HIPF. ROA.2074. When Kansas and Louisiana tried to contract with MCOs that were exempt from the HIPF, they did not receive a single qualified bid. ROA.1431-32, 1740, 1890. As a result, each Appellant-State stands to lose billions if they do not pay the HIPF. *E.g.*, ROA.1891 (estimating Louisiana's figure at $4.8 billion). Under such conditions, it matters little whether a State faces a single bazooka "to the head" or a dozen handguns. The result is the same. *NFIB*, 567 U.S. at 581.

B. The HIPF separately violates Appellant-States' immunity from federal taxation.

The HIPF is also unconstitutional as applied to States because it violates principles of intergovernmental tax immunity embodied in the Tenth Amendment. The district court rejected this claim on the ground that a tax is unconstitutional only if States bear the legal incidence of the tax, and that the States here do not because Congress "exempt[ed] the states from paying" the HIPF. ROA.4023. The MCOs pay it instead. ROA.4023. The district court also concluded that the HIPF does not "interfere unduly with the State's performance of its sovereign functions of

government." ROA.4023. Once again, under the United States's view of the world, the district court's reasoning is built on an incorrect premise because Congress did *not* exempt States from paying the HIPF when they operate their Medicaid programs through a managed-care model. U.S. Br. 22-23. This concession undermines the court's entire decision, but even without it, Appellant-States were entitled to judgment on this claim.

The Supreme Court has long held that States enjoy immunity from federal taxation that "arises from the constitutional structure and a concern for protecting state sovereignty." *South Carolina v. Baker*, 485 U.S. 505, 518 n.11 (1988). This immunity is implicated whenever a sovereign "is legally obligated to bear the costs of [a] tax" from another sovereign. *South Carolina v. Regan*, 465 U.S. 367, 413 n.11 (1984) (Stevens, J., concurring). The contours of this immunity were defined in the (splintered) decision in *New York v. United States*, 326 U.S. 572 (1946). Because there was no single majority, the "position taken by those Members who concurred in the judgment on the narrowest grounds" controls. *Marks v. United States*, 430 U.S. 188, 193 (1977). Under this view, a tax violates intergovernmental tax immunity if it either (1) discriminates against States, *New York*, 326 U.S. at 586-87, or (2) "interferes unduly with the State's sovereign functions" and does not represent a subject matter that has been part of Congress's taxing power "from the beginning," *id.* at 588; *see also Massachusetts*, 435 U.S. at 457-58.

1. *Tax incidence:* The district court erred before it even got to the *New York* test in concluding that States do not bear the legal incidence of the HIPF. Who bears the incidence of a tax does not turn entirely on who cuts the actual check to the taxing

authority. *E.g.*, *First Agric. Nat'l Bank of Berkshire Cty. v. State Tax Comm'n*, 392 U.S. 339, 347-48 (1968). Instead, courts apply a "functional approach" that considers who faces the economic burden if the tax is paid and the legal consequence if it is not. *North Dakota v. United States*, 495 U.S. 423, 435 (1990) (plurality op.); *United States v. New Mexico*, 455 U.S. 720, 742-43 (1982).

According to the United States (at 21), Congress fully intended for MCOs to pass the HIPF on to States. If true, the legal incidence of the HIPF falls on the States. *State Tax Comm'n*, 392 U.S. at 347-48.

But even though Congress did not intend to tax States, the HIPF still falls on States when it is read in context of the entire regulatory regime. Due to the structure of the Medicaid-MCO market, 100% of the economic burden of the HIPF is charged to the States. John D. Meerschaert & Mathieu Doucet, *Milliman Client Report: ACA Health Insurer Fee Estimated Impact on State Medicaid Programs and Medicaid Health Plans* 10-11 (2014). A close examination of how the HIPF functions demonstrates that the legal burden also passes to the States because MCOs face no legal consequence if the HIPF is not paid; the contracts will not go into effect, and no HIPF will be owed. The States, by contrast, do face a consequence: They do not receive Medicaid funds with all attendant legal consequences. *E.g.*, *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 918-20 (5th Cir. 2000) (addressing Section 1983 claim based on Medicaid cuts due to budget shortfall). Because the "legal effect of the transaction" falls on States, so does the legal incidence. *Alabama v. King & Boozer*, 314 U.S. 1, 12 (1941).

2. *Discrimination*: A close examination of how the HIPF functions also demonstrates that it discriminates against States. Whether a tax is discriminatory must be analyzed in terms of the "entire regulatory regime" and "with regard to the economic burdens that result." *North Dakota*, 495 U.S. at 435. A tax is not discriminatory if it applies to all healthcare contracts "whether issued by state or local governments, the Federal Government, or private corporations." *Baker*, 485 U.S. at 526-27. The HIPF is not such a tax because States are the only entities that run Medicaid programs, and the only government entities that stand to lose their exemption under Section 9010(c)(2)(B) as a result of the actuarial-soundness requirement. Because States stand to lose billions in Medicaid funding, they also face a substantially higher penalty than private entities, which may be fined as little as $10,000 for failure to pay the HIPF. 26 C.F.R. § 57.3(b)(1)(ii).

The HIPF also has a disproportionate economic impact on States. Because contracts between States and MCOs have historically had low profit margins, the structure of the Medicaid-MCO market effectively requires them to pass the entire economic burden onto States. Meerschaert & Doucet, *supra*, at 10. Private MCOs, by contrast, can afford to eat at least some portion of the additional tax. (Indeed, the HIPF was designed to tax the windfall to insurers that was supposed to come from the ACA. ROA.1617.) Forcing States to shoulder a harsher economic burden than other similarly situated entities constitutes impermissible discrimination under the Tenth Amendment. *Washington v. United States*, 460 U.S. 536, 544-45 (1983); *accord Memphis Bank & Tr. Co. v. Garner*, 459 U.S. 392, 397-98 (1983).

3. *Sovereign interest*: But even if this disproportionate impact on States were insufficient, the HIPF would still violate the States' intergovernmental tax immunity because it (1) is not a traditional source of revenue available to Congress "from the beginning," and (2) unduly interferes with state sovereignty. *Massachusetts*, 435 U.S. at 457-58.

First, the HIPF has not been part of Congress's taxing power "from the beginning." To the contrary, the HIPF is arguably a "Capitation, or other direct, Tax" that has been imposed on States without regard to population in violation of the Direct Taxation Clause. U.S. CONST. art. I, § 9, cl. 4. Specifically, the HIPF is a tax that must be paid by state taxpayers "without regard to property, profession, or any other circumstance." *NFIB*, 567 U.S. at 571 (alterations omitted). The Court need not reach that question, however, because the uncontroverted evidence in the record is that "up until the ACA became law, only the state governments were exercising any form of taxing authority focused on the health[-]insurance industry." ROA.1885.

Second, this unique federal tax interferes with state sovereignty by "forcing state governments to absorb the financial burden of implementing a federal regulatory program." *Printz*, 521 U.S. at 930. Such behavior is impermissible under our system of government because it allows "Members of Congress [to] take credit for 'solving' problems without having to ask their constituents to pay for the solutions with higher federal taxes." *Id.* Instead, state legislatures must either raise taxes or cut other spending priorities to pay for Congress's preferred healthcare policies. This is contrary to our dual system of government which contemplates that state residents may

"prefer their government devote its attention and resources to problems other than those deemed important by Congress." *New York*, 505 U.S. at 168-69.

The history of the ACA demonstrates why allowing Congress to impose the HIPF on Appellant-States would be particularly pernicious. The Act's proponents *knew* that its extreme cost would be unpopular in certain quarters. Cannan, *supra* n.5, at 145-46; Letter from President Obama to Chairman Edward M. Kennedy and Max Baucus (June 3, 2009), https://obamawhitehouse.archives.gov/the-press-office/letter-president-obama-chairmen-edward-m-kennedy-and-max-baucus (requiring deficit neutrality). That is why they went to great lengths to spread the burden to (among others) the health-insurance providers that are subject to the HIPF. To allow the United States nonetheless to force States to tax *their* constituents would create the type of blurred lines of accountability that our system—including the intergovernmental tax immunity—is designed to avoid. *Printz*, 521 U.S. at 930; *see also* ROA.1605-06 (quoting key "architect" of ACA as stating "'the lack of transparency is a huge political advantage' and that 'the stupidity of the American voter . . . was really, really critical for the thing to pass'").

VI. In the Alternative, Appellant-States Should Be Permitted to Pursue a Tax Refund.

As a result of the United States's conduct described above, it has unlawfully received nearly $500 million from Plaintiff-States, which should be returned under principles of equitable disgorgement. If the Court disagrees, however, it should remand for further consideration of Appellant-States' tax-refund claim. The district court dismissed this claim at the pleading stage because it viewed MCOs, rather than

States as the relevant "taxpayer." ROA.342-44. It subsequently refused to reconsider that order because its disgorgement order afforded Appellant-States complete relief. ROA.4412.

The district court's conclusion that States were not the HIPF's taxpayers was legally incorrect. Under 28 U.S.C. § 1346(a)(1), federal courts may hear "any civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected." In *United States v. Williams*, 514 U.S. 527, 532 (1995), the Supreme Court emphasized the "broad language" of Section 1346(a)(1). Because there are times when the party against whom a tax is *assessed* is not the party from whom it is *collected*, there is no per se rule—as the district court assumed—of direct payment to the IRS. *Id.* at 538-39; 26 C.F.R. § 57.9. Instead, there is a preference for "substance over form" and "commonsense inquires." *Williams*, 514 U.S. at 535-36.

Under *Williams* and cases like it, Appellant-States were the relevant taxpayer for the HIPF. As *Williams* recognized, "[s]ection 1346(a)(1) is a postdeprivation remedy, available" for the entity who "has paid the Government in full." *Id.* at 538. Who can seek that remedy also turns on who bore the burden of the tax, not who cut the check to the IRS. *Id.* at 539 (citing fiduciaries, executors, administrators, and certain transferees as examples of third parties who may bring tax-refund claims); *see also, e.g.*, *Colo. Nat'l Bank of Denver v. Bedford*, 310 U.S. 41, 52 (1940) ("The taxpayer is the person ultimately liable for the tax itself."). Because States bear both the economic burden if the HIPF is paid and the legal consequence if it is not, they are the relevant taxpayers and may seek a refund. If this Court decides that Appellant-States

are not entitled to have their money returned under principles of equity, they should be permitted to show that they are entitled to a refund of their monies as a matter of statute.

Conclusion

The judgment of the district court should be affirmed in part, reversed in part, and remanded for further proceedings.

Respectfully submitted.

Ken Paxton
Attorney General of Texas

Jeffrey C. Mateer
First Assistant Attorney General

David J. Hacker
Special Counsel to the
First Attorney General

Kyle D. Hawkins
Solicitor General

/s/ Lanora C. Pettit
Lanora C. Pettit
Assistant Solicitor General
lanora.pettit@oag.texas.gov

Office of the Texas Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Tel.: (512) 936-1700
Fax: (512) 474-2697

Counsel for Plaintiffs-Appellees /
Cross-Appellants States of Texas,
Kansas, Louisiana, Indiana, and
Nebraska

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On January 29, 2019, this brief was served via CM/ECF on all registered counsel and transmitted to the Clerk of the Court. Counsel further certifies that: (1) any required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (2) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1; and (3) the document has been scanned with the most recent version of Symantec Endpoint Protection and is free of viruses.

/s/ Lanora C. Pettit
Lanora C. Pettit

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This brief complies with: (1) the type-volume limitation of Federal Rule of Appellate Procedure 28.1(e)(2)(B)(i) because it contains 15,127 words, excluding the parts of the brief exempted by Rule 32(f); and (2) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Equity) using Microsoft Word (the same program used to calculate the word count).

/s/ Lanora C. Pettit
Lanora C. Pettit